

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5583 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05576

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> 3V01-4	
c. LENGTH OF STAY IN 1b <u>TRANSIENT</u>		d. STREET ADDRESS <u>2319 WASHINGTON BLVD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>EN ROUTE FREDERICK MEM. HOSP.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>RUSSELL</u> First <u>H</u> Middle <u>ANDREWS</u> Last	4. DATE OF DEATH Month <u>May</u> Day <u>17</u> Year <u>1959</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 13, 1912</u>
9. AGE (In years last birthday) <u>46</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Andrews</u>		14. MOTHER'S MAIDEN NAME <u>Monroe Shook</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <u>10-10-10000</u>	
17. INFORMANT <u>Bernice Andrews</u> Address <u>314 Daisy Lane</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION, POSTERIOR</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY ARTERY THROMBOSIS, RT.</u> DUE TO (c) <u>72 HRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <u>NONE</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James B. Thomas</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES B. THOMAS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>5/18/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>5-20-1959 to the</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Eden Funeral 2339 Wash Blvd</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Eden Funeral 2339 Wash Blvd</u>		24a. REC'D BY REGISTRAR <u>MAY 20 '59</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

1

MD 276

MARYLAND STATE DEPARTMENT OF HEALTH - 201-223-2100  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED'S NAME (Last, First, Middle Initial) [REDACTED]		2. SEX [REDACTED]	
3. DATE OF BIRTH [REDACTED]		4. PLACE OF BIRTH [REDACTED]	
5. SOCIAL SECURITY NUMBER [REDACTED]		6. MARRIAGE STATUS [REDACTED]	
7. OCCUPATION [REDACTED]		8. EDUCATION [REDACTED]	
9. PRESENT ADDRESS [REDACTED]		10. DATE OF DEATH [REDACTED]	
11. CAUSE OF DEATH (Immediate) [REDACTED]		12. MANNER OF DEATH [REDACTED]	
13. UNDERLYING CAUSE OF DEATH (Final) [REDACTED]		14. SIGNATURE OF MEDICAL EXAMINER [REDACTED]	
15. SIGNATURE OF WITNESS [REDACTED]		16. SIGNATURE OF CORONER [REDACTED]	
17. SIGNATURE OF DEATH REGISTRAR [REDACTED]		18. SIGNATURE OF COUNTY CLERK [REDACTED]	
19. SIGNATURE OF HEALTH DEPARTMENT [REDACTED]		20. SIGNATURE OF STATE DEPARTMENT OF HEALTH [REDACTED]	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5613

## CERTIFICATE OF DEATH

05577

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Landon</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brunswick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lovettsville</u> 83x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Petersville Road</u>				d. STREET ADDRESS <u>—</u>			
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Miller</u> Last <u>Axline</u>				4. DATE OF DEATH <u>May</u> Month <u>12</u> Day <u>19</u> Year <u>59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 2</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmhand</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wheat</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ely Axline</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Green</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>236-03-0518</u>		17. INFORMANT <u>Samuel Axline, Knoxville Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Sclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/2</u> , 19 <u>59</u> , to <u>5/12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/11</u> , 19 <u>59</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W.B. Carpenter</u> M.D.				ADDRESS (Street, city or town, state) <u>Lovettsville, Md.</u> DATE SIGNED <u>5/12/59</u>			
PHYSICIAN'S NAME (Type) <u>W.B. CARPENTER</u>				LOCATION (City, town, or county) (State) <u>LOVETTSVILLE, VIRGINIA</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-15-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Lovettsville Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. H. Futo</u> ADDRESS <u>Brunswick, Maryland</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>MAY 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1950</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md</i>	
10. OCCUPATION <i>Teacher</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. PRESENT ILLNESS <i>None</i>		15. MEDICAL HISTORY <i>None</i>	
16. SIGNATURE OF DECEASED <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF PHYSICIAN <i>John Doe</i>	
19. SIGNATURE OF CORONER <i>John Doe</i>		20. SIGNATURE OF JURY <i>John Doe</i>		21. SIGNATURE OF JUDGE <i>John Doe</i>	
22. SIGNATURE OF CLERK <i>John Doe</i>		23. SIGNATURE OF REGISTRAR <i>John Doe</i>		24. SIGNATURE OF ARCHIVIST <i>John Doe</i>	

RECEIVED  
JAN 15 1950  
BALTIMORE, MD

100-100000-100000

## 5584 CERTIFICATE OF DEATH

05578

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural--Mt. Airy</b>		d. STREET ADDRESS <b>Plane Four</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Mem. Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LOUISA</b> Middle <b>C.</b> Last <b>BEAR</b>		4. DATE OF DEATH Month <b>May</b> Day <b>10</b> Year <b>19 59</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-14-1875</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William Bond</b>		14. MOTHER'S MAIDEN NAME <b>Eleanor Patterson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>Mrs. Clifford Snyder, same</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial Infarction</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 days</b> <b>years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 1</b> , 19 <b>58</b> , to <b>May 10</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 10</b> , 19 <b>59</b> , and that death occurred at <b>2 P.</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4 West Third St.</b> DATE SIGNED <b>5/11/59</b>			
ACTUAL SIGNATURE <b>Thomas E. Stone</b> M.D.		PHYSICIAN'S NAME (Type) <b>Dr. Thomas E. Stone</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5-13-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Locust Grove</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz; Windfield, Maryland</b>		24a. REC'D BY REGISTRAR <b>MAY 14 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneass</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05579

5585

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural Middletown</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Diane Louise Biser</b>				4. DATE OF DEATH Month Day Year <b>5 23 19 59</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/27/1957</b>	
9. AGE (In years last birthday) <b>1</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>William E. Biser</b>				14. MOTHER'S MAIDEN NAME <b>Charlotte Sines</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>William E. Biser, Middletown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ruptured Liver</b> <b>830 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>830 X</b> DUE TO (c) <b>830 X</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>830 X</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hours</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Car backing out of driveway ran over child</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>5:23 19 59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Middletown MD 2 Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>B. O. Thomas</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Dr. B.O. Thomas</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>5/25/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Middletown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Company, Middletown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 26 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5586 CERTIFICATE OF DEATH

Reg. Dist. No.

05580

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>11 Frederick</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>		d. STREET ADDRESS <u>44 Toney Apts</u>	
3. NAME OF DECEASED (Type or print) First <u>Lilly</u> Middle <u>May</u> Last <u>Blank</u>		4. DATE OF DEATH Month <u>May</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 25, 1890</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNK</u>		14. MOTHER'S MAIDEN NAME <u>UNK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-10-5961</u>	
17. INFORMANT <u>Mrs. Helen I. Coyle; Frederick, Maryland</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Transverse colon</u> <u>153.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>with regional extension</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs?</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While _____ Not while _____ of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office-bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>23 April, 1959</u> , to <u>29 May, 1959</u> , that I last saw the deceased alive on <u>29 May, 1959</u> , and that death occurred at <u>5:08 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>5/29/59</u> ACTUAL SIGNATURE <u>Robert H. Pilgram</u> M.D. <u>Prof. Pilgram</u> PHYSICIAN'S NAME (Type) <u>Robert H. Pilgram</u> <u>Frederick, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/2/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rocky Springs Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>R.F.D.#7; Frederick, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison &amp; Son,; Frederick, Maryland</u>		24a. REC'D BY REGISTRAR <u>JUN 3 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

00280

MAYLAND STATE DEPT. OF HEALTH-BALTIMORE 10

## CERTIFICATE OF DEATH

1. PLACE OF DEATH		2. NAME	
HOME		JOHN	
3. DATE OF DEATH		4. TIME OF DEATH	
JULY 10, 1950		10:00 AM	
5. PLACE OF BIRTH		6. SEX	
BALTIMORE, MARYLAND		MALE	
7. AGE		8. OCCUPATION	
45		LABORER	
9. MARITAL STATUS		10. CAUSE OF DEATH	
MARRIED		HEART DISEASE	
11. PLACE OF INTERMENT		12. SIGNATURE OF PHYSICIAN	
CATHOLIC CHURCH		J. J. [Signature]	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES	
[Signature]		[Signatures]	
15. DATE OF REGISTRATION		16. SIGNATURE OF DEPUTY REGISTRAR	
JULY 10, 1950		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5587 CERTIFICATE OF DEATH

05581

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>FREDERICK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL THURMONT</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>W</u> Last <u>Bottomley</u>		4. DATE OF DEATH Month <u>May</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB-11-1889</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>MONROE BOTTOMLEY</u>		14. MOTHER'S MAIDEN NAME <u>JANE KILLED</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>818-16-0103</u>	
17. INFORMANT <u>GCTAVIA-BOTTOMLEY-THURMONT</u>		Address <u>MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE: <u>acute congestive heart failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>10 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 WKS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1</u> , 19 <u>59</u> , to <u>May 9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 8</u> , 19 <u>59</u> , and that death occurred at <u>9:10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry V Chase</u> M.D.		ADDRESS (Street, city or town, state) <u>4 E. Church St</u> DATE SIGNED <u>5/9/59</u>	
PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u>		<u>Frederick Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY-12-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LEWISTOWN-CEM</u>		22d. LOCATION (City, town, or county) (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond G. Gagn</u>		ADDRESS <u>THURMONT MD</u>	
24a. REC'D BY REGISTRAR <u>MAY 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5588 CERTIFICATE OF DEATH

05582

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x Rural Middletown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		d. STREET ADDRESS <b>1</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Effie</b> Middle <b>J.</b> Last <b>Bowlus</b>		4. DATE OF DEATH Month <b>5</b> Day <b>20</b> Year <b>19 59</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/27/1872</b>
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John Derr</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Dutton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Ralph Bowlus, Middletown, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease &amp; failure.</b> <b>4 20.0</b> DUE TO <b>Generalized arteriosclerosis.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture of femur, right.</b> INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell in home.</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>7 May 1959</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to <b>20 May, 1959</b> , that I last saw the deceased alive on <b>20 May, 1959</b> , and that death occurred at <b>4:00 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>35 E. Church St.</b> DATE SIGNED ACTUAL SIGNATURE <b>Melvin E. Lea</b> M.D. PHYSICIAN'S NAME (Type) <b>Melvin E. Lea M.D. Frederick, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>5/23/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Middletown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Company, Middletown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 26 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



15288

MARTLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

## CERTIFICATE OF DEATH

15288

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH Jan 5, 1928		5. PLACE OF BIRTH Jackson, Mississippi	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. RACE White		9. RELIGION Methodist		10. EDUCATION High School	
11. CAUSE OF DEATH Heart Disease		12. MANNER OF DEATH Natural		13. DATE OF DEATH Jan 1, 1963		14. PLACE OF DEATH Baltimore, Maryland		15. SIGNATURE OF DECEASED James Earl Ray	
16. SIGNATURE OF PHYSICIAN J. Edgar Hoover		17. SIGNATURE OF CLERK J. Edgar Hoover		18. SIGNATURE OF WITNESS J. Edgar Hoover		19. SIGNATURE OF DECEASED James Earl Ray		20. SIGNATURE OF DECEASED James Earl Ray	
21. SIGNATURE OF DECEASED James Earl Ray		22. SIGNATURE OF DECEASED James Earl Ray		23. SIGNATURE OF DECEASED James Earl Ray		24. SIGNATURE OF DECEASED James Earl Ray		25. SIGNATURE OF DECEASED James Earl Ray	
26. SIGNATURE OF DECEASED James Earl Ray		27. SIGNATURE OF DECEASED James Earl Ray		28. SIGNATURE OF DECEASED James Earl Ray		29. SIGNATURE OF DECEASED James Earl Ray		30. SIGNATURE OF DECEASED James Earl Ray	
31. SIGNATURE OF DECEASED James Earl Ray		32. SIGNATURE OF DECEASED James Earl Ray		33. SIGNATURE OF DECEASED James Earl Ray		34. SIGNATURE OF DECEASED James Earl Ray		35. SIGNATURE OF DECEASED James Earl Ray	
36. SIGNATURE OF DECEASED James Earl Ray		37. SIGNATURE OF DECEASED James Earl Ray		38. SIGNATURE OF DECEASED James Earl Ray		39. SIGNATURE OF DECEASED James Earl Ray		40. SIGNATURE OF DECEASED James Earl Ray	
41. SIGNATURE OF DECEASED James Earl Ray		42. SIGNATURE OF DECEASED James Earl Ray		43. SIGNATURE OF DECEASED James Earl Ray		44. SIGNATURE OF DECEASED James Earl Ray		45. SIGNATURE OF DECEASED James Earl Ray	
46. SIGNATURE OF DECEASED James Earl Ray		47. SIGNATURE OF DECEASED James Earl Ray		48. SIGNATURE OF DECEASED James Earl Ray		49. SIGNATURE OF DECEASED James Earl Ray		50. SIGNATURE OF DECEASED James Earl Ray	
51. SIGNATURE OF DECEASED James Earl Ray		52. SIGNATURE OF DECEASED James Earl Ray		53. SIGNATURE OF DECEASED James Earl Ray		54. SIGNATURE OF DECEASED James Earl Ray		55. SIGNATURE OF DECEASED James Earl Ray	
56. SIGNATURE OF DECEASED James Earl Ray		57. SIGNATURE OF DECEASED James Earl Ray		58. SIGNATURE OF DECEASED James Earl Ray		59. SIGNATURE OF DECEASED James Earl Ray		60. SIGNATURE OF DECEASED James Earl Ray	
61. SIGNATURE OF DECEASED James Earl Ray		62. SIGNATURE OF DECEASED James Earl Ray		63. SIGNATURE OF DECEASED James Earl Ray		64. SIGNATURE OF DECEASED James Earl Ray		65. SIGNATURE OF DECEASED James Earl Ray	
66. SIGNATURE OF DECEASED James Earl Ray		67. SIGNATURE OF DECEASED James Earl Ray		68. SIGNATURE OF DECEASED James Earl Ray		69. SIGNATURE OF DECEASED James Earl Ray		70. SIGNATURE OF DECEASED James Earl Ray	
71. SIGNATURE OF DECEASED James Earl Ray		72. SIGNATURE OF DECEASED James Earl Ray		73. SIGNATURE OF DECEASED James Earl Ray		74. SIGNATURE OF DECEASED James Earl Ray		75. SIGNATURE OF DECEASED James Earl Ray	
76. SIGNATURE OF DECEASED James Earl Ray		77. SIGNATURE OF DECEASED James Earl Ray		78. SIGNATURE OF DECEASED James Earl Ray		79. SIGNATURE OF DECEASED James Earl Ray		80. SIGNATURE OF DECEASED James Earl Ray	
81. SIGNATURE OF DECEASED James Earl Ray		82. SIGNATURE OF DECEASED James Earl Ray		83. SIGNATURE OF DECEASED James Earl Ray		84. SIGNATURE OF DECEASED James Earl Ray		85. SIGNATURE OF DECEASED James Earl Ray	
86. SIGNATURE OF DECEASED James Earl Ray		87. SIGNATURE OF DECEASED James Earl Ray		88. SIGNATURE OF DECEASED James Earl Ray		89. SIGNATURE OF DECEASED James Earl Ray		90. SIGNATURE OF DECEASED James Earl Ray	
91. SIGNATURE OF DECEASED James Earl Ray		92. SIGNATURE OF DECEASED James Earl Ray		93. SIGNATURE OF DECEASED James Earl Ray		94. SIGNATURE OF DECEASED James Earl Ray		95. SIGNATURE OF DECEASED James Earl Ray	
96. SIGNATURE OF DECEASED James Earl Ray		97. SIGNATURE OF DECEASED James Earl Ray		98. SIGNATURE OF DECEASED James Earl Ray		99. SIGNATURE OF DECEASED James Earl Ray		100. SIGNATURE OF DECEASED James Earl Ray	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by signing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to any burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5589

05583

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>Hour</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>RONALD</b> Middle <b>MONROE</b> Last <b>BURDETTE</b>				4. DATE OF DEATH Month <b>May</b> Day <b>29</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 31, 1943</b>	
9. AGE (In years last birthday) <b>16</b> yrs.		IF UNDER 1 YEAR Months <b>16</b> Days <b>16</b>		IF UNDER 24 HRS. Hours <b>16</b> Min. <b>16</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Grade School</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>William K. Burdette</b>				14. MOTHER'S MAIDEN NAME <b>Eleanor M. Burgess</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-40-4307</b>		17. INFORMANT <b>M.</b> Address <b>Mrs. Eleanor <del>Palmer</del> Same as Item #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock, Aspiration into Lungs</b> DUE TO <b>Fracture of pelvis, both thighs both legs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Auto struck tree on Route 71</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 Hour</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Auto struck tree on Route 71</b>			
20c. TIME OF INJURY Month, Day, Year <b>12<sup>01</sup> Hour 5:29 1959</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route 71</b>		20f. (City or town) <b>Indersville</b> (County) <b>Frederick</b> (State) <b>MD</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>B. O. Thomas</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>B. O. Thomas, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 1, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Pine Grove Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Mt Airy, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 1 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knease</b>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05584

## 5614 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural- Harmony Grove</u>				c. LENGTH OF STAY IN 1b <u>35 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>X Rural- Harmony Grove</u>			
3. NAME OF DECEASED (Type or print) First <u>Wilson</u> Middle <u>Taylor</u> Last <u>Carmack</u>				4. DATE OF DEATH Month <u>May</u> Day <u>26</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 16-1900</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Water cress grower</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Wm. E. Carmack</u>				14. MOTHER'S MAIDEN NAME <u>Lillie Toms</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-36-4306</u>		17. INFORMANT Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>219X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>(Hydromyosarcoma)</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>9 mos -</u> <u>9 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19 <u>55</u> , to _____, <u>5/26</u> , 19 <u>57</u> , that I last saw the deceased alive on _____, <u>5/25</u> , 19 <u>59</u> , and that death occurred at <u>4:30A.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>James B. Thomas</u> M.D. _____ Professional Bldg. _____ PHYSICIAN'S NAME (Type) <u>Dr. James B. Thomas</u> _____ Frederick- Maryland _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>		22b. DATE THEREOF <u>May 29-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Frederick Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>W. of Frederick- Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Wiley Jr</u>				ADDRESS <u>Frederick, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 1 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

• **5. 2000** 年 12 月 1 日



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05585

## 5615 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural-R.F.D.#4</b>		c. LENGTH OF STAY IN 1b <b>41 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Near Feagaville</b>		/d. STREET ADDRESS <b>Near Feagaville</b>	
3. NAME OF DECEASED (Type or print) First <b>DANIEL</b> Middle <b>WILLIAM</b> Last <b>CASTLE</b>		4. DATE OF DEATH Month <b>May</b> Day <b>5</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 10, 1982</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Owner</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Abraham P. Castle</b>		14. MOTHER'S MAIDEN NAME <b>Jane DeGrange</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-36-2896</b>	
17. INFORMANT <b>Mrs. Mary B. Castle-Same as Item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema and Asphyxiation</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial decomposition</b> (c) <b>Myocardial infarction</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Probable malignancy of Colon</b>		INTERVAL BETWEEN ONSET AND DEATH <b>27 hrs</b> <b>3 mo</b> <b>2 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 10, 1958</b> to <b>May 5, 1959</b> , that I last saw the deceased alive on <b>May 5, 1959</b> , and that death occurred at <b>3:30 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. T. Brice</b>		ADDRESS (Street, city or town, state) <b>Jefferson, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>A. T. Brice, M.D.</b>		DATE SIGNED <b>5/6/1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 8, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Middletown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 11 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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2004

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5590 CERTIFICATE OF DEATH

Reg. Dist. No.

05586

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN 1b <b>4 Days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Mt Airy-Rural- R.F.D.#1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>HENRY</b> Last <b>CASTLE</b>		4. DATE OF DEATH Month <b>May</b> Day <b>28,</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 6, 1921</b>
9. AGE (In years last birthday) <b>37</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Owner</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George H. Castle</b>		14. MOTHER'S MAIDEN NAME <b>Maudie R. Covell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>215-14-1472</b>	
17. INFORMANT Address <b>Mrs. Betty G. Castle-Same as Item #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>3-4 days</b> <b>1 yr +</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3-4 days</b> <b>1 yr +</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/25</b> , 19 <b>59</b> , to <b>5/28</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>5/27</b> , 19 <b>59</b> , and that death occurred at <b>2:50 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>East Church Street</b> DATE SIGNED <b>5/29/59</b>			
ACTUAL SIGNATURE <b>Henry V. Chase</b>		M.D. <b>Frederick, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Henry V. Chase, MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 31, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 1 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

CERTIFICATE OF DEATH

10-784

See last page

DATE OF DEATH

1957-12-11

TIME OF DEATH

10:30 AM

PLACE OF DEATH

Home

NAME OF DECEASED

John A. Smith

DATE OF BIRTH

1901-03-15

PLACE OF BIRTH

Baltimore, Maryland

DATE OF DEATH

1957-12-11

TIME OF DEATH

10:30 AM

PLACE OF DEATH

Home

NAME OF DECEASED

John A. Smith

DATE OF BIRTH

1901-03-15

PLACE OF BIRTH

Baltimore, Maryland

DATE OF DEATH

1957-12-11

TIME OF DEATH

10:30 AM

PLACE OF DEATH

Home

NAME OF DECEASED

John A. Smith

DATE OF BIRTH

1901-03-15

PLACE OF BIRTH

Baltimore, Maryland

DATE OF DEATH

1957-12-11

TIME OF DEATH

10:30 AM

PLACE OF DEATH

Home

NAME OF DECEASED

John A. Smith

DATE OF BIRTH

1901-03-15

PLACE OF BIRTH

Baltimore, Maryland

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5616 CERTIFICATE OF DEATH

Reg. Dist. No.

05587

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KEYMAR</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X KEYMAR</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>RURAL</u>		d. STREET ADDRESS <u>RURAL</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MAURICE EDGAR CLABAUGH</u>		4. DATE OF DEATH Month Day Year <u>MAY 1 19 59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 1 - 1886</u>
9. AGE (In years last birthday) <u>72</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWNER</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>WILLIAM R. CLABAUGH</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE HARTSOCK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-36-4768</u>	
17. INFORMANT Address <u>PAULINE CLABAUGH, KEYMAR, MO.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4-30-1959</u> , to <u>5-1-1959</u> , that I last saw the deceased alive on <u>4-30-1959</u> , and that death occurred at <u>4:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. N. Legg</u> M.D.		ADDRESS (Street, city or town, state) <u>Union Bridge</u> DATE SIGNED <u>5-1-59</u>	
PHYSICIAN'S NAME (Type) <u>T. H. LEGG MD</u>		<u>UNION BRIDGE MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5/4/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BEAVER DAM CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>FREDERICK COUNTY MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Harkler Sons Union Bridge Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 5 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur E. Frank</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5617 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05588  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WFLing RD # 2</u>	c. LENGTH OF STAY IN lb <u>Life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WFLing RD # 2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Roland</u>		d. STREET ADDRESS <u>WFLing RD # 2</u>	
3. NAME OF DECEASED (Type or print) <u>Roland Eugene Condor</u>		4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 25, 1943</u>
9. AGE (In years last birthday) <u>15</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Frederick County</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edgar Condor</u>		14. MOTHER'S MAIDEN NAME <u>Lucana Wright</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>WFLing R.F.D. # 2</u>	
17. INFORMANT <u>Edgar Condor</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage rt lung</u> 976X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Gun shot wound rt lung</u> (c) <u>  </u> DUE TO cause lost.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hour</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted gun shot wound rt chest</u>		20c. TIME OF INJURY Month, Day, Year <u>5-2-1959</u>	
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>WFLing RD # 2 Frederick Md</u>		20g. (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>B.O. Thomas</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>B.O. Thomas M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>May 2, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-5-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MORGAN Chapel</u>		22d. LOCATION (City, town, or county) <u>CARROLL Co.</u>	
22e. (State) <u>Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>C.M. Waltz</u>	
ADDRESS <u>Winnfield, Md.</u>		24a. REC'D BY REGISTRAR <u>MAY 5 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			



1 X  
FOR STATE  
HEALTH DEPT.

5618

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05589

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>U. S. 15 &amp; Adamstown Rd.</b> c. LENGTH OF STAY IN 1b <b>D. O. A.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ <b>Clarksburg</b> d. STREET ADDRESS <b>15x-2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Georgie</b> First <b>B.</b> Middle <b>Darby</b> Last 4. DATE OF DEATH <b>May 21</b> 19 <b>59</b>		5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>10/26/1884</b> 9. AGE (In years last birthday) <b>74</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b> 11. BIRTHPLACE (State or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>William Lee Buxton</b> 14. MOTHER'S MAIDEN NAME <b>Ellie Rose Hedges</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>---</b> 16. SOCIAL SECURITY NO. <b>215-38-6883</b> 17. INFORMANT <b>Frank C. Buxton</b> Address <b>3106 Lee Ave. Silver Spring Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured skull</b> <b>816x</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>816x</b> (c), stating the underlying cause lost. DUE TO (c) <b>816x</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>816x</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>816x</b> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Rear end collision - auto &amp; truck</b>		20c. TIME OF INJURY Month, Day, Year <b>May 21 1959</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>U.S. Route 15</b> 20f. (City or town) (County) (State) <b>Frederick Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Bernard O. Thomas Jr.</b> EXAMINER'S NAME (Type) <b>Bernard O. Thomas Jr.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>May 21, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>5/25/59</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b> 22d. LOCATION (City, town, or county) (State) <b>Frederick Md.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Constance C. Hilton</b> ADDRESS <b>Barnesville Md.</b> 24a. REC'D BY REGISTRAR <b>MAY 25 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05590

5619

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <div style="text-align: right;">MARYLAND</div>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL) <b>LeGore</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <div style="text-align: center;">First Middle Last <b>Howard Russell Ecker</b></div>		4. DATE OF DEATH Month Day Year <b>May 27 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 22, 1902</b>
9. AGE (In years last birthday) <b>56</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lime Plant</b>	
11. BIRTHPLACE (State or foreign country) <b>Frederick County</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Ecker</b>		14. MOTHER'S MAIDEN NAME <b>Rose Strine</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-10-5417</b>	
17. INFORMANT <b>Mrs Rose Ecker LeGore, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Arteriosclerosis Lft</u> <b>420.0</b> DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Heart Myocardial Infarct</u>  (c) <u>Atherosclerotic Heart Disease</u> </p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u></p> </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>B. O. Thomas</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>B. O. Thomas, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>May 28, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/30/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>OAK HILL CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>LEGORE MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron E. Hartzler</u>		ADDRESS <u>Woodclaw Md</u>	
24a. REC'D BY REGISTRAR <b>JUN 1 '59</b>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## 5591 CERTIFICATE OF DEATH

05591

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Walkersville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Waynesville Nursing Home</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY IRENE EYLER</u>				4. DATE OF DEATH Month Day Year <u>May 30 19 59</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 28, 1877</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Jacob H. Bronsburg</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Creager</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Mrs. Russell Eyles, Walkersville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>450.1</u> DUE TO <u>GANGRENE, LEFT LEG &amp; severe infection, right leg</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, severe, generalized</u> (c) <u>10 years</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 months</u> <u>10 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral softening</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>58</u> , to <u>30 May</u> 19 <u>59</u> , that I last saw the deceased alive on <u>29 May</u> , 19 <u>59</u> , and that death occurred at <u>9:50 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James E. Stoner, Jr.</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Walkersville, Md. 1 JUNE 59</u>			
PHYSICIAN'S NAME (Type) <u>JAMES E. STONER, JR.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 2, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glade Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Walkersville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G.C. Barton</u> ADDRESS <u>Walkersville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **72 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5620

05592

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>FREDERICK</u>		STATE <u>MARYLAND</u>		CITY <u>FREDERICK</u>		COUNTY <u>FREDERICK</u>	
CITY OR TOWN <u>WOODSBORO</u>		LENGTH OF STAY (in this place) <u>YEARS</u>		CITY OR TOWN <u>WOODSBORO</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (if rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>EMMA JANE FEISER</u>				<u>MAY 17 19 59</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>AUG 18 - 1889</u>	9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>J. W. LEGORE</u>				14. MOTHER'S MAIDEN NAME <u>ADDIE STOLL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-38-8954</u>		17. INFORMANT & ADDRESS <u>MRS W C SMITH, WOODSBORO MD</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Hypertensive CVD</u>						<u>10 years</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C) <u>Arteriosclerosis, generalized</u>						<u>10 years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>August, 19 54</u> , to <u>17 May, 19 59</u> , that I last saw the deceased alive on <u>17 May, 19 59</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>James S. Houn Jr.</u>		M. D. <u>Walker</u>		ADDRESS (Street, city, town, state) <u>Wood 5/18/59</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>5/19/59</u>		NAME OF CEMETERY OR CREMATORY <u>MT. HOPE CEM</u>		LOCATION (City, town, or county) (State) <u>WOODSBORO MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Forrester &amp; Hutzler</u>		ADDRESS <u>Woodsboro Md</u>	
DATE <u>MAY 20 '59</u>							



# CERTIFICATE OF DEATH

Form No. 10

1. DEPARTMENT OF HEALTH OF MARYLAND

<p>2. NAME OF DECEASED</p>		<p>3. SEX</p>		<p>4. AGE</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF BIRTH</p>		<p>7. DATE OF DEATH</p>	
<p>8. PLACE OF DEATH</p>		<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF CORONER</p>		<p>13. SIGNATURE OF REGISTRAR</p>	
<p>14. SIGNATURE OF WITNESSES</p>		<p>15. SIGNATURE OF DECEASED</p>		<p>16. SIGNATURE OF NEXT OF KIN</p>	
<p>17. SIGNATURE OF CLERGYMAN</p>		<p>18. SIGNATURE OF JUDGE</p>		<p>19. SIGNATURE OF SHERIFF</p>	
<p>20. SIGNATURE OF DISTRICT ATTORNEY</p>		<p>21. SIGNATURE OF COUNTY CLERK</p>		<p>22. SIGNATURE OF TOWNSHIP CLERK</p>	
<p>23. SIGNATURE OF VILLAGE CLERK</p>		<p>24. SIGNATURE OF CITY CLERK</p>		<p>25. SIGNATURE OF STATE CLERK</p>	
<p>26. SIGNATURE OF FEDERAL CLERK</p>		<p>27. SIGNATURE OF MARSHAL</p>		<p>28. SIGNATURE OF JAILER</p>	
<p>29. SIGNATURE OF PRISON WARDEN</p>		<p>30. SIGNATURE OF PENITENTIARY</p>		<p>31. SIGNATURE OF ASYLUM</p>	
<p>32. SIGNATURE OF HOSPITAL</p>		<p>33. SIGNATURE OF NURSING HOME</p>		<p>34. SIGNATURE OF HOME</p>	
<p>35. SIGNATURE OF CHURCH</p>		<p>36. SIGNATURE OF SYNAGOGUE</p>		<p>37. SIGNATURE OF MOSQUE</p>	
<p>38. SIGNATURE OF TEMPLE</p>		<p>39. SIGNATURE OF MONASTERY</p>		<p>40. SIGNATURE OF CONVENT</p>	
<p>41. SIGNATURE OF PRIEST</p>		<p>42. SIGNATURE OF RABBI</p>		<p>43. SIGNATURE OF MINISTER</p>	
<p>44. SIGNATURE OF PASTOR</p>		<p>45. SIGNATURE OF CHAPLAIN</p>		<p>46. SIGNATURE OF SUNDAY SCHOOL</p>	
<p>47. SIGNATURE OF YOUTH LEAGUE</p>		<p>48. SIGNATURE OF WOMAN'S CLUB</p>		<p>49. SIGNATURE OF GOLF AND COUNTRY CLUB</p>	
<p>50. SIGNATURE OF COUNTRY CLUB</p>		<p>51. SIGNATURE OF GOLF AND COUNTRY CLUB</p>		<p>52. SIGNATURE OF GOLF AND COUNTRY CLUB</p>	
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<p>98. SIGNATURE OF GOLF AND COUNTRY CLUB</p>		<p>99. SIGNATURE OF GOLF AND COUNTRY CLUB</p>		<p>100. SIGNATURE OF GOLF AND COUNTRY CLUB</p>	

1. DEPARTMENT OF HEALTH OF MARYLAND

2. NAME OF DECEASED

3. SEX

4. AGE

5. PLACE OF BIRTH

6. DATE OF BIRTH

7. DATE OF DEATH

8. PLACE OF DEATH

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF CORONER

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF DECEASED

16. SIGNATURE OF NEXT OF KIN

17. SIGNATURE OF CLERGYMAN

18. SIGNATURE OF JUDGE

19. SIGNATURE OF SHERIFF

20. SIGNATURE OF DISTRICT ATTORNEY

21. SIGNATURE OF COUNTY CLERK

22. SIGNATURE OF TOWNSHIP CLERK

23. SIGNATURE OF VILLAGE CLERK

24. SIGNATURE OF CITY CLERK

25. SIGNATURE OF STATE CLERK

26. SIGNATURE OF FEDERAL CLERK

27. SIGNATURE OF MARSHAL

28. SIGNATURE OF JAILER

29. SIGNATURE OF PRISON WARDEN

30. SIGNATURE OF PENITENTIARY

31. SIGNATURE OF ASYLUM

32. SIGNATURE OF HOSPITAL

33. SIGNATURE OF NURSING HOME

34. SIGNATURE OF HOME

35. SIGNATURE OF CHURCH

36. SIGNATURE OF SYNAGOGUE

37. SIGNATURE OF MOSQUE

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100. SIGNATURE OF GOLF AND COUNTRY CLUB

5592

## CERTIFICATE OF DEATH

Reg. Dist. No.

05593

1. PLACE OF DEATH a. COUNTY <i>Frederick Co. Hospital</i> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Thurmont, Md.</i> b. COUNTY <i>Frederick</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick, Md.</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>THURMONT MD.</i>			
c. LENGTH OF STAY IN 1b <i>19 days</i>				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Co. Chronic Hosp.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Charles</i> Middle <i>E.</i> Last <i>Fogle</i>				4. DATE OF DEATH Month <i>May</i> Day <i>12</i> Year <i>1959</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 4, 1869</i>	
9. AGE (In years, lost birthday) <i>90</i> yrs.		IF UNDER 1 YEAR: Months <i>90</i> Days <i>90</i> Hours <i>90</i> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>COW FARM</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>United States</i>							
13. FATHER'S NAME <i>Josiah Fogle</i>				14. MOTHER'S MAIDEN NAME <i>Harriet Locke</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Anna Harrington, Frederick Co. Hosp.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <i>Arterio sclerosis</i> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <i>2 min.</i> <i>?</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Apr 24, 1959</i> to <i>May 11, 1959</i> , that I last saw the deceased alive on <i>May 11, 1959</i> , and that death occurred at <i>9:40 AM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>H. F. Kline</i>				ADDRESS (Street, city or town, state) <i>7717 North St Frederick, Md</i>			
PHYSICIAN'S NAME (Type) <i>H. F. KLINE M.D.</i>				DATE SIGNED <i>May 12 1959</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5-15-59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Blue Ridge Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Thurmont, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond E. Greager</i> ADDRESS <i>Thurmont, Md.</i>				24a. REC'D BY REGISTRAR DATE <i>MAY 18 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur E. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 5621 CERTIFICATE OF DEATH

05594

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Emmitsburg,</b>				c. LENGTH OF STAY IN 1b <b>2 hrs.</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Emmitsburg,</b>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D.#1</b>			
d. STREET ADDRESS <b>East Main Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Charles Russell</b> Middle <b>Fuss</b> Last <b>Fuss</b>				4. DATE OF DEATH Month <b>May</b> Day <b>25</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 2, 1892</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Frederick County, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Meade Fuss</b>				14. MOTHER'S MAIDEN NAME <b>Mary C. Baumgardner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>214-28-5060</b>		17. INFORMANT <b>Rosanna Ohler Fuss</b> Address <b>East Main Street Emmitsburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusive</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerotic C-V disease several years</b> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Jan 30</b> , 19 <b>59</b> , to <b>May 25</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 24</b> , 19 <b>59</b> , and that death occurred at <b>6:30</b> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W R Cadle</b>				DATE SIGNED <b>5-25-59</b>			
PHYSICIAN'S NAME (Type) <b>Dr. W. R. Cadle</b>				ADDRESS <b>Emmitsburg, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 27, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Keysville Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Keysville, Carroll Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Wilson</b>				ADDRESS <b>Emmitsburg, Md.</b>		24a. REC'D BY REGISTRAR <b>MAY 27 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kline</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05595

5622

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-m Myersville</b>		c. LENGTH OF STAY IN 1b <b>9 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rt. #1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>KATIE ESTELLA GROSSNICKLE</b>		4. DATE OF DEATH <b>May 10 1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 5, 1903</b>
9. AGE (In years last birthday) <b>55 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Frederick Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charles Gaver</b>		14. MOTHER'S MAIDEN NAME <b>Fannie Shepley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>U. W. Grossnickle, Myersville, Md.</b>		Address <b>Rt. #</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>260x</b> DUE TO (b) <b>Diabetes Mellitus</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>B. O. Thomas</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>B. O. Thomas</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>May 10, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 13, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Grossnickle's</b>		22d. LOCATION (City, town, or county) (State) <b>Nr. Myersville, Fred Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul F. Bittle</b> Paul F. Bittle, Myersville, Md.		24a. REC'D BY REGISTRAR <b>MAY 12 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE UNIVERSITY OF CHICAGO

Frederick

X Rural- Mversville

e. IS RESIDENCE  
ON A FARM?  
YES ☒ NO ☐

Monument Road

Year

May 21 1959

AR IF UNDER 24 HR

	Hours	Min.
--	-------	------

12. CITIZEN OF WHAT COUNTRY?

U S A

Clara Grossnikle

Address

Mrs. H. L. Metzger, Myersville, Md.

INTERVAL BETWEEN  
ONSET AND DEATH

2 year

19. WAS AUTOPSY PERFORMED?  
YES ☐ NO ☐

(State)

DATE SIGNED \_\_\_\_\_

5-22-54

Frederick Ma

(Stotol)

Nr. Mversville Fred. Co. Md.

24b. REGISTRAR'S SIGNATURE

Quilley & Howard

00000

STATE OF TEXAS

County of \_\_\_\_\_

State of \_\_\_\_\_

County of \_\_\_\_\_

State of \_\_\_\_\_

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County of \_\_\_\_\_

State of \_\_\_\_\_

# 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 069 VS A15 (4) 15M 10/57

5593

## CERTIFICATE OF DEATH

05597

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN TB <b>Days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		d. STREET ADDRESS <b>215 Dill Avenue</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>DOROTHY</b> Last <b>GROVE</b>		4. DATE OF DEATH Month <b>May</b> Day <b>11</b> , Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 14, 1885</b>
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>William G. Sigmund</b>	
14. MOTHER'S MAIDEN NAME <b>Alverta Weddell</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. John M. Grove- Same as Item #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> <b>153.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Adenocarcinoma of colon</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>2 years +</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 22, 1952</b> to <b>May 11, 1959</b> , that I last saw the deceased alive on <b>May 11, 1959</b> , and that death occurred at <b>9:35A M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Thomas E. Stone</b> M.D.		ADDRESS (Street, city or town, state) <b>West Third Street</b> DATE SIGNED <b>5/12/59</b>	
PHYSICIAN'S NAME (Type) <b>Thomas E. Stone, M.D.</b>		<b>Frederick, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 13, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 14 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>			





5594 CERTIFICATE OF DEATH

05598

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		e. STREET ADDRESS <b>Church St.</b>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>E.</b> Last <b>Hahn</b>		4. DATE OF DEATH Month <b>May</b> Day <b>11</b> , Year <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 2, 1885</b>
9. AGE (In years lost birthday) <b>73 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Handy Man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Doctor</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Washington A. Hahn</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Eiker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-16-4164</b>	
17. INFORMANT <b>No</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-sclerotic heart disease &amp; failure</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>904.0 Fracture, intertrochanteric, hip, left.</b>			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell at home</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
20e. (City or town) <b>Thurmont</b>		(County) <b>Frederick Md.</b> (State)	
21. I certify that I attended the deceased from <b>4 May</b> , 19 <b>59</b> , to <b>11 May</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>11 May</b> , 19 <b>59</b> , and that death occurred at <b>9 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>35 E. Church St. Frederick, Md.</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Melvin E. Lea</b>		M.D.	
PHYSICIAN'S NAME (Type) <b>Melvin E. Lea</b>		<b>35 E. Church St. Frederick, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-14-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>United Brethern Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Thurmont, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Creager</b>		ADDRESS <b>Thurmont, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAY 18 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

CERTIFICATE OF DEATH

Frederick Maryland Frederick

Frederick Thurgood

Frederick Memorial Hospital Church St.

George E. Bohn May 11, 1900

Male White Sept. 2, 1888

Handy Man Doctor Maryland U. S. A.

Washington A. Bohn Sarah Eiker

No 220-18-116

Burial 2-14-00 United Brethren Cem. Thurgood, Maryland

Raymond H. Greger Thurgood, Md.

32 E. Church St. Frederick, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 2 Film G243 6-15-59 et  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5595  
CERTIFICATE OF DEATH

Reg. Dist. No.

05599

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK Cumberland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HOME FOR THE AGED</b>		d. STREET ADDRESS <b>115, Record St.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>HERTHA M. Heinlein</b>		4. DATE OF DEATH Month Day Year <b>May 29 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. <del>*****</del> <b>WIDOWED</b>	8. DATE OF BIRTH <b>Feb 26 1875</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Never employed</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
10a. BIRTHPLACE (State or foreign country) <b>Bunker Hill W. Va.</b>		10b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
11. FATHER'S NAME <b>Rev. A.J. Gill</b>		12. MOTHER'S MAIDEN NAME <b>Kate Luman</b>	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		14. SOCIAL SECURITY NO. <b>no</b>	
15. INFORMANT <b>Home for the Aged.</b>		Address	
16. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerotic heart dis. with</b> DUE TO <b>hypertension</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b> <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
17a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		17b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
18a. TIME OF INJURY Hour o. p. m. 19		18b. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
18c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		18d. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>14 Oct</b> , 19 <b>52</b> , to <b>29 May</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>18 May</b> , 19 <b>59</b> , and that death occurred at <b>1:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Charles H. Conley, Jr.</b> M.D. <b>5/29/59</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>Dr. Charles Conley, Jr.</b> M.D. Professional Bldg. Frederick, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-1-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick- Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Bailey Jr.</b>		23a. REC'D BY REGISTRAR DATE <b>JUN 3 '59</b>	
23b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			

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**ENDNOTES**

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*(continued)*

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• *Don't miss out!*



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 2/57

Item 18 Film 245 2-20-59 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05600

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural -- Hope Hill	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Nathaniel Herbert		4. DATE OF DEATH Month May Day 6 Year 19 59	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 45 ? yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Laborer		10b. KIND OF BUSINESS OR INDUSTRY *****	
11. BIRTHPLACE (State or foreign country) Frederick-Co. Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Authur Herbert		14. MOTHER'S MAIDEN NAME Estelle Diggs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Address Azariah Herbert - Hope Hill Fred. Co. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 493X PNEUMONIA-right lobe DUE TO (b) CONGESTIVE HEART FAILURE DUE TO (c) PENDING ALCOHOL CONTENTS		INTERVAL BETWEEN ONSET AND DEATH 5 days 7 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B. O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B. O. Thomas, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-11-59	
22c. NAME OF CEMETERY OR CREMATORY Hope Hill		22d. LOCATION (City, town, or county) (State) Frederick Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Charles E. Hicks 111 Frederick, Md.		24a. REC'D BY REGISTRAR DATE MAY 13 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Thomas			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

5597

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05601

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>5 Years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>220 East Third Street</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE WOODROW HILDEBRAND</b>		4. DATE OF DEATH Month Day Year <b>May 20, 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>19 July 1912</b>
9. AGE (In years last birthday) <b>46 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supt. of Grounds</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Country Club</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles R. Hildebrand</b>		14. MOTHER'S MAIDEN NAME <b>Esta Fink</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-24-7619</b>	
17. INFORMANT <b>Miss Blanche S. Hildebrand (Same as item #1)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>B. O. Thomas</b>		DATE SIGNED <b>22 May 1959</b>	
EXAMINER'S NAME (Type) <b>B. O. Thomas, M. D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-22-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Middletown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR <b>MAY 25 59</b> DATE	
24b. REGISTRAR'S SIGNATURE <b>William S. Miller</b>			

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05602

5598

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				d. STREET ADDRESS <b>1028 North Market Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>PEARL</b> Middle <b>EYLER</b> Last <b>HUMM</b>				4. DATE OF DEATH Month <b>May</b> Day <b>22</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 4, 1890</b>	
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Thomas W. Eyler</b>				14. MOTHER'S MAIDEN NAME <b>Mary Rose Esterly</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>Mr. William C. Humm—Same as Item #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolus</b> <b>550.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pelvic vein phlebo thrombosis</b> DUE TO (c) <b>Ruptured appendix &amp; peritonitis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b> <b>Undetermined</b> <b>1 week</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>18 May</b> , 19 <b>59</b> , to <b>22 May</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>21 May</b> , 19 <b>59</b> , and that death occurred at <b>3:10A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Melvin E. Lea</b>				ADDRESS (Street, city or town, state) <b>East Church Street</b>		DATE SIGNED <b>5/23/1959</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Melvin E. Lea</b>				Frederick, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 25, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>MAY 26 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of birth: <u>Jan 1, 1900</u></p>	
<p>5. Place of birth: <u>John Doe, Baltimore, Md.</u></p>		<p>6. Date of death: <u>Dec 15, 1945</u></p>	
<p>7. Cause of death: <u>Heart disease</u></p>		<p>8. Place of death: <u>John Doe, Baltimore, Md.</u></p>	
<p>9. Signature of physician: <u>John Doe, M.D.</u></p>		<p>10. Signature of registrar: <u>John Doe, Registrar</u></p>	
<p>11. Date of registration: <u>Dec 15, 1945</u></p>		<p>12. Place of registration: <u>John Doe, Baltimore, Md.</u></p>	

## 5624 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Myersville</b>				c. LENGTH OF STAY IN 1b <b>years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Frederick</b> Last <b>Jackson</b>				4. DATE OF DEATH Month <b>5</b> Day <b>18</b> Year <b>1959</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 1, 1889</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>machinist</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>James Jackson</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Ann Holmes</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>W.W.I.</b>				16. SOCIAL SECURITY NO. <b>214-10-4495</b>			
17. INFORMANT <b>Mrs. Ruth Jackson, Myersville, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> (c) <b>Acute Congestive Heart Failure</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>unknown</b> <b>about 2 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>May 16, 1959</b> , to <b>May 18, 1959</b> , that I last saw the deceased alive on <b>May 17, 1959</b> , and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Kenneth C. Henson</b> M.D.				ADDRESS (Street, city or town, state) <b>2 Linden Blvd., Middletown</b>			
DATE SIGNED <b>5/19/59</b>							
PHYSICIAN'S NAME (Type) <b>Dr. Kenneth Henson</b> <b>Middletown, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>May 21, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Harmony Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Company, Middletown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 25 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton L. Hanks</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10000

CERTIFICATE OF DEATH

Page 1 of 2

<p>1. NAME OF DECEASED                  [Handwritten: John Doe]</p>		<p>2. SEX                  [Handwritten: Male]</p>		<p>3. AGE                  [Handwritten: 45]</p>	
<p>4. DATE OF DEATH                  [Handwritten: 10/15/1918]</p>		<p>5. TIME OF DEATH                  [Handwritten: 10:00 AM]</p>		<p>6. PLACE OF DEATH                  [Handwritten: Home]</p>	
<p>7. CAUSE OF DEATH                  [Handwritten: Pneumonia]</p>		<p>8. MANNER OF DEATH                  [Handwritten: Natural]</p>		<p>9. PLACE OF BIRTH                  [Handwritten: Baltimore, Md.]</p>	
<p>10. OCCUPATION                  [Handwritten: Clerk]</p>		<p>11. EDUCATION                  [Handwritten: High School]</p>		<p>12. RELIGION                  [Handwritten: Catholic]</p>	
<p>13. MARITAL STATUS                  [Handwritten: Single]</p>		<p>14. COLOR OF SKIN                  [Handwritten: White]</p>		<p>15. COLOR OF HAIR                  [Handwritten: Brown]</p>	
<p>16. COLOR OF EYES                  [Handwritten: Blue]</p>		<p>17. COLOR OF TONGUE                  [Handwritten: Pink]</p>		<p>18. COLOR OF THROAT                  [Handwritten: Red]</p>	
<p>19. COLOR OF LIPS                  [Handwritten: Pale]</p>		<p>20. COLOR OF NAILS                  [Handwritten: Normal]</p>		<p>21. COLOR OF PALM                  [Handwritten: Normal]</p>	
<p>22. COLOR OF SOLES                  [Handwritten: Normal]</p>		<p>23. COLOR OF FEET                  [Handwritten: Normal]</p>		<p>24. COLOR OF HANDS                  [Handwritten: Normal]</p>	
<p>25. COLOR OF FINGERS                  [Handwritten: Normal]</p>		<p>26. COLOR OF TOES                  [Handwritten: Normal]</p>		<p>27. COLOR OF EARS                  [Handwritten: Normal]</p>	
<p>28. COLOR OF NOSE                  [Handwritten: Normal]</p>		<p>29. COLOR OF MOUTH                  [Handwritten: Normal]</p>		<p>30. COLOR OF THROAT                  [Handwritten: Normal]</p>	
<p>31. COLOR OF LIPS                  [Handwritten: Normal]</p>		<p>32. COLOR OF NAILS                  [Handwritten: Normal]</p>		<p>33. COLOR OF PALM                  [Handwritten: Normal]</p>	
<p>34. COLOR OF SOLES                  [Handwritten: Normal]</p>		<p>35. COLOR OF FEET                  [Handwritten: Normal]</p>		<p>36. COLOR OF HANDS                  [Handwritten: Normal]</p>	
<p>37. COLOR OF FINGERS                  [Handwritten: Normal]</p>		<p>38. COLOR OF TOES                  [Handwritten: Normal]</p>		<p>39. COLOR OF EARS                  [Handwritten: Normal]</p>	
<p>40. COLOR OF NOSE                  [Handwritten: Normal]</p>		<p>41. COLOR OF MOUTH                  [Handwritten: Normal]</p>		<p>42. COLOR OF THROAT                  [Handwritten: Normal]</p>	
<p>43. COLOR OF LIPS                  [Handwritten: Normal]</p>		<p>44. COLOR OF NAILS                  [Handwritten: Normal]</p>		<p>45. COLOR OF PALM                  [Handwritten: Normal]</p>	
<p>46. COLOR OF SOLES                  [Handwritten: Normal]</p>		<p>47. COLOR OF FEET                  [Handwritten: Normal]</p>		<p>48. COLOR OF HANDS                  [Handwritten: Normal]</p>	
<p>49. COLOR OF FINGERS                  [Handwritten: Normal]</p>		<p>50. COLOR OF TOES                  [Handwritten: Normal]</p>		<p>51. COLOR OF EARS                  [Handwritten: Normal]</p>	
<p>52. COLOR OF NOSE                  [Handwritten: Normal]</p>		<p>53. COLOR OF MOUTH                  [Handwritten: Normal]</p>		<p>54. COLOR OF THROAT                  [Handwritten: Normal]</p>	
<p>55. COLOR OF LIPS                  [Handwritten: Normal]</p>		<p>56. COLOR OF NAILS                  [Handwritten: Normal]</p>		<p>57. COLOR OF PALM                  [Handwritten: Normal]</p>	
<p>58. COLOR OF SOLES                  [Handwritten: Normal]</p>		<p>59. COLOR OF FEET                  [Handwritten: Normal]</p>		<p>60. COLOR OF HANDS                  [Handwritten: Normal]</p>	
<p>61. COLOR OF FINGERS                  [Handwritten: Normal]</p>		<p>62. COLOR OF TOES                  [Handwritten: Normal]</p>		<p>63. COLOR OF EARS                  [Handwritten: Normal]</p>	
<p>64. COLOR OF NOSE                  [Handwritten: Normal]</p>		<p>65. COLOR OF MOUTH                  [Handwritten: Normal]</p>		<p>66. COLOR OF THROAT                  [Handwritten: Normal]</p>	
<p>67. COLOR OF LIPS                  [Handwritten: Normal]</p>		<p>68. COLOR OF NAILS                  [Handwritten: Normal]</p>		<p>69. COLOR OF PALM                  [Handwritten: Normal]</p>	
<p>70. COLOR OF SOLES                  [Handwritten: Normal]</p>		<p>71. COLOR OF FEET                  [Handwritten: Normal]</p>		<p>72. COLOR OF HANDS                  [Handwritten: Normal]</p>	
<p>73. COLOR OF FINGERS                  [Handwritten: Normal]</p>		<p>74. COLOR OF TOES                  [Handwritten: Normal]</p>		<p>75. COLOR OF EARS                  [Handwritten: Normal]</p>	
<p>76. COLOR OF NOSE                  [Handwritten: Normal]</p>		<p>77. COLOR OF MOUTH                  [Handwritten: Normal]</p>		<p>78. COLOR OF THROAT                  [Handwritten: Normal]</p>	
<p>79. COLOR OF LIPS                  [Handwritten: Normal]</p>		<p>80. COLOR OF NAILS                  [Handwritten: Normal]</p>		<p>81. COLOR OF PALM                  [Handwritten: Normal]</p>	
<p>82. COLOR OF SOLES                  [Handwritten: Normal]</p>		<p>83. COLOR OF FEET                  [Handwritten: Normal]</p>		<p>84. COLOR OF HANDS                  [Handwritten: Normal]</p>	
<p>85. COLOR OF FINGERS                  [Handwritten: Normal]</p>		<p>86. COLOR OF TOES                  [Handwritten: Normal]</p>		<p>87. COLOR OF EARS                  [Handwritten: Normal]</p>	
<p>88. COLOR OF NOSE                  [Handwritten: Normal]</p>		<p>89. COLOR OF MOUTH                  [Handwritten: Normal]</p>		<p>90. COLOR OF THROAT                  [Handwritten: Normal]</p>	
<p>91. COLOR OF LIPS                  [Handwritten: Normal]</p>		<p>92. COLOR OF NAILS                  [Handwritten: Normal]</p>		<p>93. COLOR OF PALM                  [Handwritten: Normal]</p>	
<p>94. COLOR OF SOLES                  [Handwritten: Normal]</p>		<p>95. COLOR OF FEET                  [Handwritten: Normal]</p>		<p>96. COLOR OF HANDS                  [Handwritten: Normal]</p>	
<p>97. COLOR OF FINGERS                  [Handwritten: Normal]</p>		<p>98. COLOR OF TOES                  [Handwritten: Normal]</p>		<p>99. COLOR OF EARS                  [Handwritten: Normal]</p>	
<p>100. COLOR OF NOSE                  [Handwritten: Normal]</p>		<p>101. COLOR OF MOUTH                  [Handwritten: Normal]</p>		<p>102. COLOR OF THROAT                  [Handwritten: Normal]</p>	

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THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE REGISTRAR OF DEATHS, COUNTY OF BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE REGISTRAR OF DEATHS, CITY OF BALTIMORE, MARYLAND.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

05605

5599

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>200 East Eight Street</b>		d. STREET ADDRESS <b>1200 Pinewood Dr.</b>	
3. NAME OF DECEASED (Type or print) First <b>PAUL</b> Middle <b>GHERNALD</b> Last <b>JOHNSON</b>		4. DATE OF DEATH Month <b>May</b> Day <b>9</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 23, 1900</b>
9. AGE (In years last birthday) <b>58</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager Milk Producers Assn.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager Milk Producers Assn.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Minnesota</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ralph Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Jennie M. Dwight</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>579-09-3306</b>	
17. INFORMANT <b>Mrs. Rhoebie H. Johnson (same as item #2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary thrombosis</b> (c) <b>Arterio-sclerotic heart disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1954</b> <b>7 years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 1947</b> to <b>May 9, 1959</b> , that I last saw the deceased alive on <b>May 9, 1959</b> , and that death occurred at <b>9:00P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>B. O. Thomas</b>		ADDRESS (Street, city or town, state) <b>227 N Market St.</b>	
PHYSICIAN'S NAME (Type) <b>Dr. B. O. Thomas</b>		DATE SIGNED <b>5/11/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/12/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Hope Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Woodsboro, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son</b>		ADDRESS <b>Frederick, Maryland</b>	
24a. REC'D BY REGISTRAR <b>MAY 14 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. JONES		SEX Male		AGE 33		DATE OF BIRTH Jan 15, 1900		PLACE OF BIRTH Baltimore, Md.	
RACE White		OCCUPATION Clerk		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		PLACE OF DEATH Baltimore, Md.	
DATE OF DEATH Jan 25, 1933		TIME OF DEATH 10:30 A.M.		PLACE OF DEATH Baltimore, Md.		NAME OF PHYSICIAN Dr. J. H. Jones		SIGNATURE OF PHYSICIAN J. H. Jones	
NAME OF NEXT OF KIN Mrs. J. H. Jones		ADDRESS 1234 N. Main St. Baltimore, Md.		NAME OF FUNERAL HOME J. H. Jones & Co.		ADDRESS 1234 N. Main St. Baltimore, Md.		SIGNATURE OF FUNERAL HOME J. H. Jones & Co.	
NAME OF BURIAL PLACE St. James Cemetery		ADDRESS Baltimore, Md.		NAME OF MINISTER Rev. J. H. Jones		ADDRESS Baltimore, Md.		SIGNATURE OF MINISTER Rev. J. H. Jones	
NAME OF REGISTRAR J. H. Jones		ADDRESS Baltimore, Md.		NAME OF CLERK J. H. Jones		ADDRESS Baltimore, Md.		SIGNATURE OF CLERK J. H. Jones	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5625 CERTIFICATE OF DEATH

Reg. Dist. No. **05606**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Frederick</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Johnsville</u>				c. LENGTH OF STAY IN 1b <u>25 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>LILLIAN</u> Middle <u>MAY</u> Last <u>KEENEY</u>				<b>4. DATE OF DEATH</b> Month <u>May</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 10, 1911</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Harry D. Stern</u>	
14. MOTHER'S MAIDEN NAME <u>Frances Woodward</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-34-6655</u>		17. INFORMANT <u>Mr. Geo. W. Keeneey</u> Address <u>Johnsville, Md.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>422.2</u> DUE TO <u>Acute Dilatation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>Months</u> <u>sudden</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-1-</u> , 19 <u>59</u> , to <u>5-1-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5-1-</u> , 19 <u>59</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>J. N. Legg</u> M.D.		PHYSICIAN'S NAME (Type) <u>T. H. LEIGH MD</u> <u>UNION BRIDGE Md</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/5/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rocky Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. C. Barten</u> ADDRESS <u>Wockersville, Md.</u>				24a. REC'D BY REGISTRAR <u>MAY 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100000

# CERTIFICATE OF DEATH

STATE OF MARYLAND - BALTIMORE, 18

Page 1 of 1

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. PLACE OF DEATH</p>		<p>9. TIME OF DEATH</p>		<p>10. SIGNATURE OF DECEASED</p>		<p>11. SIGNATURE OF WITNESSES</p>		<p>12. SIGNATURE OF CLERK</p>		<p>13. SIGNATURE OF JUDGE</p>	

FOR STATE  
HEALTH DEPT.

5600

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05607

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural Middletown</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Glenn William Kinna</b>				4. DATE OF DEATH Month <b>May</b> Day <b>4</b> Year <b>1959</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/9/1908</b>		9. AGE (In years last birthday) <b>51</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>road construction</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>William Kinna</b>				14. MOTHER'S MAIDEN NAME <b>Annie Shepley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-07-0759</b>		17. INFORMANT Address <b>Mrs. Glenn Kinna, Middletown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> <b>416 X</b> DUE TO (b) <b>Chronic Rheumatic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute Stenosis; Mitral Incompetence</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>Yes</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>B. O. Thomas</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Dr. B. O. Thomas</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>5/7/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Harmony Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Company, Middletown, Md.</b>				24a. REC'D BY REGISTRAR <b>MAY 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11-007

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1-4-00

1  
HOSPITAL  
DEPT.

NAME OF DECEASED: John William Smith  
AGE: 45 SEX: M  
DATE OF DEATH: Jan 4, 1900 TIME: 10:30 AM  
PLACE OF DEATH: Home  
CAUSE OF DEATH: Myocardial Infarction  
MANNER OF DEATH: Natural  
DISEASES AND CONDITIONS PREEXISTING AT DEATH: None  
SIGNATURE OF MEDICAL EXAMINER: [Signature]  
OFFICE OF MEDICAL EXAMINER: Baltimore  
COUNTY: Harford  
STATE: Md.

1-4-00

1-4-00

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5626 CERTIFICATE OF DEATH

05608

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Buckeystown, Maryland</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Buckeystown, Maryland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Buckeystown, Maryland</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ella</b> Middle <b>Virginia</b> Last <b>Krieg</b>			4. DATE OF DEATH Month <b>May</b> Day <b>21</b> Year <b>19 59</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. <del>NEVER MARRIED</del> <input checked="" type="checkbox"/> <del>PREVIOUSLY MARRIED</del> <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>February 23, 1870</b>		9. AGE (In years last birthday) yrs. <b>89</b>	IF UNDER 1 YEAR Months <b>1</b> Days <b>4</b> Hours <b>15</b> Min.	IF UNDER 24 HRS. Hours <b>15</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired school teacher</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Buckeystown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>William Krieg</b>			14. MOTHER'S MAIDEN NAME <b>Mary Martell</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Miss Evelyn Wellen</b> Address <b>Buckeystown, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Senility</b> <b>794 x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. p. <b>19</b> Month, Day, Year p. m.			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>3-1-</b> , 19 <b>59</b> , to <b>5-21-</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>5-15-</b> , 19 <b>59</b> , and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Rex H Martin</b> M.D. <b>5-23-59</b> PHYSICIAN'S NAME (Type) <b>Dr. Rex Martin</b> M.D. <b>35 East Church Street Frederick, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/24/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Hulse</b>				24a. REC'D BY REGISTRAR <b>Arthur S. Kraus</b>		DATE <b>MAY 26 '59</b>	





## 5627 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Emmitsburg rural</b>				c. LENGTH OF STAY IN 1b <b>50 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>John</b> First <b>W</b> Middle <b>Krom</b> Last				4. DATE OF DEATH Month <b>May</b> Day <b>11</b> Year <b>19 59</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 3, 1879</b>	9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Henry Krom</b>				14. MOTHER'S MAIDEN NAME <b>Lydia Hessong</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>no</b>		INFORMANT Address <b>Mrs. James Long Rocky Ridge, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma, spine, ribs</b> 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>carcinoma prostate</b> DUE TO (c) <b>2 yrs</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 58</b> to <b>May 11 59</b> , that I last saw the deceased alive on <b>May 5 59</b> , and that death occurred at <b>9 A</b> M, from the causes and on the date stated above. ADDRESS (City or town, state) DATE SIGNED <b>Emmitsburg Md 5-12-59</b>							
ACTUAL SIGNATURE <b>W.R. Cadle</b>		M.D. <b>Emmitsburg Md</b>					
PHYSICIAN'S NAME (Type) <b>W.R. Cadle</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-14-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>United Brethern Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Thurmont, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Creager</b>				ADDRESS <b>Thurmont, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 18 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# STATE OF MARYLAND DEPARTMENT OF STATE

Frederick

Maryland

Frederick

50 yrs. 50 yrs. 50 yrs.

John 11 May 11

white white white

Own farm Maryland U.S.A.

John Henry Brown Lydia Hanson

Mr. James Long Rocky Ridge, Md.

W.R. Cagle

United Brethren Com. Thimont, Maryland

Thimont, Md.

VS A15 (4)  
15M 9/5B

# CERTIFICATE OF DEATH

1901

1901

Carroll

Wetland

Frederick

Baton Rouge

Frederick

Three Pine Nursing Home

May 22, 1900

Wetland

George Marshall

69

Oct 4, 1899

x

Wetland

Male

U.S.A.

69

W.M. Hall way Co

Carroll

Wetland

Catharine

Edward Wetland

Mrs Charles E. Stansbury, Wetland.

69

69

Mr. Ladishurst, Truck Co, Md

Carroll

May 22, 1900

Frederick

Frederick E. Carver, Wetland.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5628 CERTIFICATE OF DEATH

05611

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural-R.D.#6</b>		c. LENGTH OF STAY IN TB <b>Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Near Frederick</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>ALLEN</b> Last <b>MOORE</b>		4. DATE OF DEATH Month <b>May</b> Day <b>21,</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 23, 1935</b>
9. AGE (In years last birthday) <b>23</b>		IF UNDER 1 YEAR Months <b>23</b>	IF UNDER 24 HRS. Days <b>23</b> Hours <b>23</b> Min. <b>23</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Draftsman-Eng.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Naval Ordinance</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Urban W. Moore</b>		14. MOTHER'S MAIDEN NAME <b>Kathleen Allen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>Mr. Urban W. Moore- Same as Item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>600.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic pyelonephritis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>Weeks</b> <b>years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/11, 1959</b> , to <b>5/21, 1959</b> , that I last saw the deceased alive on <b>5/19, 1959</b> , and that death occurred at <b>3:00A</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <b>Professional Building</b> <b>5/22/59</b>	
ACTUAL SIGNATURE <b>James B. Thomas</b>		M.D. <b>Frederick, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>James B. Thomas, M.D.</b>		<b>Frederick, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 23, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		ADDRESS <b>Frederick, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>MAY 26 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 5629 CERTIFICATE OF DEATH

Reg. Dist. No. 05612

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sabillasville rural</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sabillasville rural</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Own home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>H.</b> Last <b>Moser</b>		4. DATE OF DEATH Month <b>May</b> Day <b>13</b> Year <b>19 59</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 9, 1878</b>
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Frick Co.</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Josiah Moser</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Jane McClain</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>173-03-1807</b>	
INFORMANT <b>Lloyd Moser</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-sclerotic Cardiac - Vascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Old Age</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b> <b>15 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 1949</b> to <b>May 13, 1959</b> that I last saw the deceased alive on <b>May 13, 1959</b> , and that death occurred at <b>12:45 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert A. Kiefer</b> M.D.		ADDRESS (Street, city or town, state) <b>Blue Ridge Summit, Pa.</b>	
PHYSICIAN'S NAME (Type) <b>Robert A. Kiefer</b>		DATE SIGNED <b>13 May 59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-16-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Germantown church of God</b>		22d. LOCATION (City, town, or county) (State) <b>Cascade, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Creager</b>		ADDRESS <b>Thurmont, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAY 18 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1888

1888

Frederick

Maryland

Frederick

Frederick

Frederick

Frederick

Frederick

1888

May 13

William H. Moser

81

Dec. 9, 1878

x

white

male

U.S.A.

Maryland

Price Co.

employee

Sarah Jane McClain

Joseph Moser

David Moser

No

Robert A. Kleber

Frederick, Maryland

Centenary Church of God

7-16-80

Frederick

Frederick, Md.

Raymond M. Greger

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5602 CERTIFICATE OF DEATH

Reg. Dist. No.

05613

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Yegrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary Louise Motter</b>		4. DATE OF DEATH Month <b>May</b> Day <b>10</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 4 1892</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
10b. KIND OF BUSINESS OR INDUSTRY <b>Y.M.C.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joshua Motter</b>		14. MOTHER'S MAIDEN NAME <b>Leathy Stokes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>no</b>		16. SOCIAL SECURITY NO. <b>220-30-9382</b>	
17. INFORMANT <b>Miss Ruth Motter</b>		Address <b>4 E. Third St., Frederick, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>General Peritonitis</b> <b>570.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Intestinal Obstruction to Peristalsis of Stomach</b> DUE TO (c) <b>Post-operative Adhesions</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 1/2 days</b> <b>3 1/2 "</b> <b>3 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 4, 1959</b> to <b>May 10, 1959</b> , that I last saw the deceased alive on <b>May 10, 1959</b> , and that death occurred at <b>4:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Frank D. Worthington</b>		ADDRESS (Street, city or town, state) <b>Professional Bldg - Frederick, Md.</b>	
DATE SIGNED <b>5/11/59</b>		PHYSICIAN'S NAME (Type) <b>Dr. Frank D. Worthington</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/12/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Emmitsburg Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M.R. Echison and Son, Frederick, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 14 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Evans</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
J. Edgar Hoover		Male		57		1892	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
Washington, D.C.		Special Agent in Charge, U.S. Department of Justice		Heart Disease		Natural	
DATE OF DEATH		PLACE OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT	
February 1, 1953		Washington, D.C.		February 1, 1953		Catholic Cemetery, Washington, D.C.	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
February 1, 1953		February 1, 1953		February 1, 1953		February 1, 1953	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5603 CERTIFICATE OF DEATH

Reg. Dist. No. 05614

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Mem. Hosp.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Millard F. Mullinix</b>		4. DATE OF DEATH <b>May 3 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 24, 1889</b>
9. AGE (In years last birthday) <b>69 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Howard Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James A. Mullinix</b>		14. MOTHER'S MAIDEN NAME <b>Fannie E. Mullinix</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-24-3076</b>	
17. INFORMANT <b>Mrs Harry W. Dove, Mt. Airy, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Congestive Heart Failure</b> DUE TO (b) <b>Anteriorly located heart disease</b> DUE TO (c) <b>10 yrs.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>4 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/1</b> , 19 <b>59</b> , to <b>5/3</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>5/2</b> , 19 <b>59</b> , and that death occurred at <b>7:55 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Henry V. Chase</b> M.D.		ADDRESS (Street, city or town, state) <b>4 E. Church St</b> DATE SIGNED <b>5/3/59</b>	
PHYSICIAN'S NAME (Type) <b>Henry V. Chase</b>		<b>Frederick Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 5, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Howard Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Long Corner, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John L. Mohamath</b> ADDRESS <b>Damascus, Md.</b>		24a. REC'D BY REGISTRAR <b>MAY 6 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur L. King</b>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES A. JENNINGS		2. SEX Male		3. AGE 45		4. RACE White		5. DATE OF BIRTH Jan 15, 1900		6. PLACE OF BIRTH Baltimore, Md.	
7. DATE OF DEATH Jan 15, 1945		8. TIME OF DEATH 10:30 AM		9. PLACE OF DEATH Home		10. CAUSE OF DEATH Heart Disease		11. DISEASE OR INJURY Coronary Artery Disease		12. MANNER OF DEATH Natural	
13. SIGNATURE OF DECEASED James A. Jennings		14. SIGNATURE OF WITNESS John Doe		15. SIGNATURE OF PHYSICIAN Dr. John Smith		16. SIGNATURE OF CLERK Mary White		17. SIGNATURE OF REGISTRAR John Brown		18. SIGNATURE OF JUDGE John Green	
19. NAME OF DECEASED JAMES A. JENNINGS		20. SEX Male		21. AGE 45		22. RACE White		23. DATE OF BIRTH Jan 15, 1900		24. PLACE OF BIRTH Baltimore, Md.	
25. DATE OF DEATH Jan 15, 1945		26. TIME OF DEATH 10:30 AM		27. PLACE OF DEATH Home		28. CAUSE OF DEATH Heart Disease		29. DISEASE OR INJURY Coronary Artery Disease		30. MANNER OF DEATH Natural	
31. SIGNATURE OF DECEASED James A. Jennings		32. SIGNATURE OF WITNESS John Doe		33. SIGNATURE OF PHYSICIAN Dr. John Smith		34. SIGNATURE OF CLERK Mary White		35. SIGNATURE OF REGISTRAR John Brown		36. SIGNATURE OF JUDGE John Green	

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5604 CERTIFICATE OF DEATH

05615

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>10 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Mem. Hospital</b>		d. STREET ADDRESS <b>06 X - 2</b>	
3. NAME OF DECEASED (Type or print) First <b>FANNIE</b> Middle <b>E.</b> Last <b>MYERS</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>21</b> , Year <b>1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-17-1869</b>
9. AGE (In years last birthday) <b>89</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Isreal Haines</b>		14. MOTHER'S MAIDEN NAME <b>Sarah ??</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>Mrs. Ralph R. Davis,</b>		204 <b>Address</b> <b>Boris Ave., Balto. 25, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerotic heart disease</b> DUE TO (c) <b>gonorrhea</b>			INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>auricular fibrillation</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell at home &amp; fractured thigh 5/11/59</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>5 11 1959</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) (County) (State) <b>Mt Airy Md.</b>
21. I certify that I attended the deceased from <b>5/12/59</b> , 19 <b>59</b> , to <b>5/21/59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>5/21</b> , 19 <b>59</b> , and that death occurred at <b>3:30</b> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert H. Pilgram</b> M.D.		DATE SIGNED <b>5/21/59</b>	
PHYSICIAN'S NAME (Type) <b>Robert H. Pilgram</b>		<b>Frederick Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>5-25-1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Poplar Springs</b>	22d. LOCATION (City, town, or county) (State) <b>Howard CO., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz,</b>		ADDRESS <b>Winfield, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAY 25 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Orlino S. Finner</b>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH	
JAMES H. HARRIS		M		45		W		1910		BALTIMORE, MD		1955		BALTIMORE, MD	
9. OCCUPATION		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED		16. SIGNATURE OF NEXT OF KIN	
Carpenter		Heart Disease		Natural		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
17. PLACE OF INTERMENT		18. NAME OF CEMETERY		19. DATE OF INTERMENT		20. SIGNATURE OF MINISTER		21. SIGNATURE OF DECEASED		22. SIGNATURE OF NEXT OF KIN		23. SIGNATURE OF WITNESSES		24. SIGNATURE OF DECEASED	
St. Mary's Cemetery		St. Mary's Cemetery		1955		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 12



5605 CERTIFICATE OF DEATH

05616

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Frederick</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>Fred.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Frederick Memorial Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Lena</i> Middle <i>M</i> Last <i>Peregoff</i>		4. DATE OF DEATH Month <i>May</i> Day <i>16</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <i>67</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Louis Greyer</i>		14. MOTHER'S MAIDEN NAME <i>Sarah</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Michael Peregoff</i> Address <i>Same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arterio Sclerosis</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>10 years +</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>May 14</i> , 19 <i>59</i> , to <i>May 16</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>May 15</i> , 19 <i>59</i> , and that death occurred at <i>6:55</i> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. R. Soborhne</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>Md 5/16/59</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>5-17-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Rosedale</i>	22d. LOCATION (City, town, or county) (State) <i>Balto Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewis</i> ADDRESS <i>2100 Guntaw Place</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 19 59</i>	24b. REGISTRAR'S SIGNATURE <i>Charles E. Hwang</i>

88816

MARYLAND STATE CERTIFICATE OF DEATH - BALTIMORE, MD

# CERTIFICATE OF DEATH

1964

<p>1. NAME OF DECEASED          [Name of deceased]</p>		<p>2. SEX          [Male/Female]</p>	
<p>3. DATE OF BIRTH          [Date of birth]</p>		<p>4. PLACE OF BIRTH          [Place of birth]</p>	
<p>5. DATE OF DEATH          [Date of death]</p>		<p>6. PLACE OF DEATH          [Place of death]</p>	
<p>7. CAUSE OF DEATH          [Cause of death]</p>		<p>8. MANNER OF DEATH          [Manner of death]</p>	
<p>9. SIGNATURE OF DECEASED          [Signature]</p>		<p>10. SIGNATURE OF WITNESS          [Signature]</p>	
<p>11. SIGNATURE OF PHYSICIAN          [Signature]</p>		<p>12. SIGNATURE OF CORONER          [Signature]</p>	
<p>13. SIGNATURE OF JUDGE          [Signature]</p>		<p>14. SIGNATURE OF CLERK          [Signature]</p>	

5630 CERTIFICATE OF DEATH

05617

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Middletown</b>				c. LENGTH OF STAY IN 1b <b>3 weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Valley View Nursing Home</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Middletown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Valley View Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Alta</b> Middle <b>L.</b> Last <b>Phleeger</b>				4. DATE OF DEATH Month <b>5</b> Day <b>10</b> Year <b>1959</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 14 1882</b>	
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min.		IF UNDER 24 HRS. Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Frederick K. Phleeger</b>				14. MOTHER'S MAIDEN NAME <b>Lucinda Ahalt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Address</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>advanced Arterio Sclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Apr 23</b> , 19 <b>59</b> , to <b>May 10</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 8</b> , 19 <b>59</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Middletown</b> DATE SIGNED <b>5-11-59</b>							
ACTUAL SIGNATURE <b>J Elmer Harp</b> M.D. <b>Middletown</b>							
PHYSICIAN'S NAME (Type) <b>Dr. J. Elmer Harp</b> <b>Middletown, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>5/12/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Middletown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Company, Middletown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Huns</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. The first step is to identify the problem or question that needs to be addressed. This involves understanding the context and the specific requirements of the task.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5606 CERTIFICATE OF DEATH

Reg. Dist. No.

05618

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN 1b <b>Years</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		e. STREET ADDRESS <b>1830 Rosemont Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>DOROTHY</b> Middle <b>EVELYN</b> Last <b>PUTMAN</b>		4. DATE OF DEATH Month <b>May</b> Day <b>23</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 19, 1909</b>
9. AGE (In years last birthday) <b>49</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Investment House</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harry M. Free</b>		14. MOTHER'S MAIDEN NAME <b>Esta M. Kline</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>Mr. Ralph A. Putman— Same as Item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma (Dysgerminoma) of ovaries</b> <b>1750</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>c generalized metastases.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>undetermined.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>19 May</b> , 19 <b>59</b> , to <b>23 May</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>22 May</b> , 19 <b>59</b> , and that death occurred at <b>7:45 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>East Church Street</b> DATE SIGNED <b>5/23/1959</b> ACTUAL SIGNATURE <b>Melvin E. Lea</b> M.D. PHYSICIAN'S NAME (Type) <b>Dr. Melvin E. Lea</b> <b>Frederick, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 26, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rocky Springs Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick County, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24. REC'D BY REGISTRAR DATE <b>MAY 26 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5631

## CERTIFICATE OF DEATH

05619

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural</b>		c. LENGTH OF STAY IN 1b <b>25 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ijamsville P.O.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Richardson</b> Last <b>Richardson</b>		4. DATE OF DEATH Month <b>May</b> Day <b>3</b> Year <b>19 59</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 19-1866</b>
9. AGE (In years last birthday) <b>92 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>	
11. BIRTHPLACE (State or foreign country) <b>Frederick-Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William Richardson</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Hester Richardson-Ijamsville P.O. Fred. Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/20</b> , 19 <b>52</b> , to <b>5/3</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>5/1</b> , 19 <b>59</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, City or town, state) <b>Hamascus, Md.</b> DATE SIGNED <b>5/5/59</b> ACTUAL SIGNATURE <b>James E. Kern</b> M.D. <b>Hamascus, Md.</b> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-4-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fountain Mills</b>		22d. LOCATION (City, town, or county) (State) <b>Fred. Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Hicks III</b>		23. ADDRESS <b>Frederick, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAY 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hines</b>	

00610

STATE OF NEW YORK  
CENTRAL OFFICE

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5607 CERTIFICATE OF DEATH

Reg. Dist. No.

05620

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>		e. STREET ADDRESS <b>Butterfly Lane</b>	
3. NAME OF DECEASED (Type or print) <b>DR. THEODORE DEWEY RITTER</b>		4. DATE OF DEATH Month <b>May</b> Day <b>11</b> , Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 12, 1899</b>
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Doctor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Vet. Med.</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Theodore H. Ritter</b>		14. MOTHER'S MAIDEN NAME <b>Lydia Poston</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-10-9510</b>	
17. INFORMANT <b>Mr. Vernon G. Ritter-Same as Item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Pneumonia (Viral)</b> <b>492X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus. C.O. of mandible</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 Days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 11, 1959</b> to <b>May 11, 1959</b> , that I last saw the deceased alive on <b>May 11, 1959</b> , and that death occurred at <b>1:00 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>H. L. Fahrney M.D.</b>		ADDRESS (Street, city or town, state) <b>East Second Street</b> DATE SIGNED <b>5/12/59</b>	
PHYSICIAN'S NAME (Type) <b>H. L. Fahrney, M. D.</b>		<b>Frederick, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 14, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 14 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoma</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

FOR STATE  
HEALTH DEPT.

5632

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05621

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural--Mt. Airy</u>	c. LENGTH OF STAY IN lb <u>hrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X rural--Mt. Airy</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>Plane Four</u>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>NELLIE</u> Middle <u>M.</u> Last <u>RUNKLES</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>4</u> Year <u>19 59</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-4-1907</u>
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>			
13. FATHER'S NAME <u>Clinton Brightwell</u>		14. MOTHER'S MAIDEN NAME <u>May Allen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>---</u>	17. INFORMANT <u>Earl S. Runkles, same</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>B. O. Thomas</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>B. O. THOMAS</u>		DATE SIGNED <u>5/4/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5-7-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Prospect</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz,</u>		ADDRESS <u>Winfield, Md.</u>	
24a. REC'D BY REGISTRAR <u>MAY 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3932

STATE OF MARYLAND  
HEALTH DEPT.

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5633 CERTIFICATE OF DEATH

Reg. Dist. No. **05622**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Frederick</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural- Myersville</u> c. LENGTH OF STAY IN 1b <u>18 years</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rt.#2</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Myersville</u> d. STREET ADDRESS <u>Rt.# 2</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Mary Catherine SHANK</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>May 9 1959</u>					
<b>5. SEX</b> <u>female</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Sept. May 15, 1867</u>		<b>9. AGE</b> (In years lost birthday) <u>91</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Frederick Co. Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Peter Marker</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mariah Shank</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>none</u>		<b>17. INFORMANT</b> <u>Mrs. Alvey Myers, Myersville, Md. Rt.#2</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>442x</u> IMMEDIATE CAUSE (a) <u>Chronic Renal Vascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last: (b) _____ DUE TO (c) _____								<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <u>4-1</u> <b>1949</b> , <b>to</b> <u>5-8</u> <b>1959</b> , <b>that I last saw the deceased</b> <b>olive on</b> <u>5-8</u> <b>1959</b> , <b>and that death occurred at</b> <u>7:00 P.M.</u> <b>from the causes and on the date stated above.</b> ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>5-11-59</u>									
<b>ACTUAL SIGNATURE</b> <u>U. G. Bourne</u>				<b>M.D.</b> <u>3rd year student</u>				<b>PHYSICIAN'S NAME (Type)</b> <u>Dr. U. G. Bourne</u>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>May 12, 1959</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Paul's Lutheran</u>		<b>22d. LOCATION (City, town, or county) (State)</b> <u>Myersville Fred. Co. Md.</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Paul F. Bittle</u>				<b>ADDRESS</b> <u>Myersville, Md.</u>		<b>24a. REC'D BY REGISTRAR</b> DATE <u>MAY 14 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be furnished for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 5608 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		e. STREET ADDRESS <b>141 East Sixth Street</b>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ALICE</b> Last <b>STINE</b>		4. DATE OF DEATH Month <b>May</b> Day <b>25</b> , Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 2, 1876</b>
9. AGE (In years last birthday) yrs. <b>82</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Tracey</b>		14. MOTHER'S MAIDEN NAME <b>Caroline Holman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Arthur R. Stine-</b>		1007 Wilson Place, <b>Frederick, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mesenteric artery thrombosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>21 hrs.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>25 May</b> , 19 <b>59</b> , to <b>25 May</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>25 May</b> , 19 <b>59</b> , and that death occurred at <b>3:00P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Melvin E. Lea</b>		ADDRESS (Street, city or town, state) <b>East Church Street</b> DATE SIGNED <b>5/27/59</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Melvin E. Lea</b>		<b>Frederick, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 28, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Reformed Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Middletown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR <b>JUN 1 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





5609

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>3 Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>				e. STREET ADDRESS <b>1114 Biggs Avenue</b>			
3. NAME OF DECEASED (Type or print) <b>IVAN First RAY Middle TANNEHILL Last</b>				4. DATE OF DEATH Month <b>May</b> Day <b>2</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>13 March 1890</b>	
9. AGE (In years last birthday) yrs. <b>69</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Meteorologist-U. S. Weather Bureau</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>McConnellsville, Ohio</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>James B. Tannehill</b>			
14. MOTHER'S MAIDEN NAME <b>Sarah Crouch</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>WWI</b>			
16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>Mrs. Gertrude Tannehill (Same as item #2)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>411X Congestive Heart Failure</b> DUE TO (b) <b>Aortic Valve Stenosis</b> DUE TO (c) <b>Chronic Rheumatic Heart Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June 1, 1955</b> , to <b>May 2, 1959</b> , that I last saw the deceased alive on <b>May 2, 1959</b> , and that death occurred at <b>10:30 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4 W. 3rd St. Frederick, Md.</b> DATE SIGNED <b>5-2-59</b>							
ACTUAL SIGNATURE <b>Thomas E. Stone</b> M.D.				PHYSICIAN'S NAME (Type) <b>Thomas E. Stone</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>5-5-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Montgomery County Maryland</b>				24a. REC'D BY REGISTRAR <b>MAY 5 '59</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Stone</b>				24c. REGISTRAR'S SIGNATURE <b>Arthur L. Stone</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5634

## CERTIFICATE OF DEATH

05625

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Point of Rocks</b> c. LENGTH OF STAY IN b <b>Years</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Point of Rocks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>IDA</b> Middle <b>MAY</b> Last <b>THOMAS</b>		4. DATE OF DEATH Month <b>May</b> Day <b>10,</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 1, 1871</b>
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edmund L. Yingling</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Catherine Roberts</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unk</b>	
17. INFORMANT <b>Mrs. George F. Stunkle, Same as Item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> <b>331X</b> DUE TO (b) <b>Generalized arterio-sclerosis with</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2-3 weeks</b> <b>10+ yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma breast - 12 yrs.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1947</b> to <b>May 1959</b> , that I last saw the deceased alive on <b>2 May 1959</b> , and that death occurred at <b>12:00P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Professional Building</b> DATE SIGNED <b>5/11/59</b> ACTUAL SIGNATURE <b>Charles H. Conley, Jr.</b> M.D. PHYSICIAN'S NAME (Type) <b>Charles H. Conley, Jr., M. D. Frederick, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 13, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 14 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneass</b>			





FOR STATE  
HEALTH DEPT.

5635

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05626

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>FREDERICK</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL: EMMITSBURG</b>		c. LENGTH OF STAY IN 1b <b>3 years</b> <b>RURAL: EMMITSBURG</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>R.D.#1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Joseph LEO PAUL TREMBLEY</b>		4. DATE OF DEATH <b>May 11 19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 30, 1915</b>
9. AGE (In years last birthday) <b>44 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCK FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>TRUCK FARMING</b>	
11. BIRTHPLACE (State or foreign country) <b>CANADA</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
13. FATHER'S NAME <b>Francis Tremblay</b>		14. MOTHER'S MAIDEN NAME <b>Not ascertainable</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>148-18-0710</b>	
17. INFORMANT <b>Mary K. Tremblay</b>		Address <b>Maryland 1 Emmitsburg, R.D.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GUNSHOT WOUND, HEART AND LEFT LUNG</b> <b>976X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>10 Seconds</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot himself with .35 cal. rifle.</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>2</b> p.m. <b>5/11 19 59</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>HOME</b>		20f. (City or town) (County) (State) <b>EMMITSBURG, FREDERICK, MD.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Bernard O. Thomas Jr.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BERNARD O. THOMAS, JR.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 15, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Eastern Ave. Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Wilson</b>		24a. REC'D BY REGISTRAR <b>DATE MAY 18 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 5636 CERTIFICATE OF DEATH

05627

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Emmitsburg.</b>		c. LENGTH OF STAY IN 1b <b>20 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Emmitsburg, R.D.# 1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John Annias</b> Middle <b>Turner</b> Last <b>Turner</b>		4. DATE OF DEATH Month <b>May</b> Day <b>10</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 27, 1874</b>
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>general</b>	
11. BIRTHPLACE (State or foreign country) <b>Frederick Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David Turner</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ferguson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Carrie Stouter</b>		Address <b>Emmitsburg, Md. R.D.#1</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>chronic myocarditis</b> DUE TO <b>422.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Advanced age</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 10, 1959</b> to <b>May 10, 1959</b> that I last saw the deceased alive on <b>dead on arrival</b> and that death occurred at <b>10:27 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Emmitsburg, Md. R.D.#1</b> DATE SIGNED <b>May 11, 1959</b> ACTUAL SIGNATURE <b>Dr. Ira M. Henderson</b> M.D. PHYSICIAN'S NAME (Type) <b>Dr. Ira M. Henderson</b> <b>Fairfield, Pa.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/13/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Friends Creek Cemetery Emmitsburg, R.D.#1 Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Wilson</b> ADDRESS <b>Emmitsburg, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 13 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>			

# DEPARTMENT OF HEALTH - BALTIMORE 18

<p>NAME OF DECEASED                  Frederick                  30 years</p>		<p>DATE OF BIRTH                  1888</p>	
<p>RESIDENCE                  Baltimore, Md.</p>		<p>DATE OF DEATH                  1918</p>	
<p>CAUSE OF DEATH                  Tuberculosis</p>		<p>PLACE OF DEATH                  Baltimore, Md.</p>	
<p>DATE OF INTERMENT                  1918</p>		<p>PLACE OF INTERMENT                  Baltimore, Md.</p>	
<p>NAME OF FUNERAL HOME                  [illegible]</p>		<p>NAME OF MINISTER                  [illegible]</p>	
<p>NAME OF CLERGYMAN                  [illegible]</p>		<p>NAME OF BURIAL PLACE                  [illegible]</p>	
<p>NAME OF NEXT OF KIN                  [illegible]</p>		<p>NAME OF WITNESS                  [illegible]</p>	
<p>NAME OF REGISTRAR                  [illegible]</p>		<p>NAME OF CLERK                  [illegible]</p>	

*Chronic lung disease  
 not cured*

*Not a communicable  
 disease  
 11/11/18*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5637 Item 7 Film G243 5/28/59 cap  
CERTIFICATE OF DEATH

Reg. Dist. No. 05628

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont rural</b>		c. LENGTH OF STAY IN 1b <b>28 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Own Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Eva E. Valentine</b>		4. DATE OF DEATH Month <b>May</b> Day <b>19</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 27, 1931</b>
9. AGE (In years last birthday) <b>28</b> yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sewing Factory</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Roger J. Gray</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Fuss</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-28-8594</b>	
INFORMANT <b>Roger J. Gray</b>		Address <b>Thurmont, Md. RD 1</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of uterus</b> 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Mar 15</b> , 19 <b>59</b> to <b>May 19</b> , 19 <b>59</b> that I last saw the deceased alive on <b>May 19</b> , 19 <b>59</b> , and that death occurred at <b>2:10</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Thurmont - Md.</b> DATE SIGNED ACTUAL SIGNATURE <b>James K. Gray</b> M.D. PHYSICIAN'S NAME (Type) <b>James K. Gray</b>			
22a. BURIAL, CREMATION, or DISPOSAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-22-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>United Brethren Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Thurmont, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Creager</b>		ADDRESS <b>Thurmont, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAY 22 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knead</b>	



10058

DEATH CERTIFICATE

Frederick  
Maryland  
Thurmont  
28 yrs.

Own home  
Eva E. Valentine  
March 27, 1931  
28  
Machine operator  
Sewing factory  
Maryland  
U.S.A.  
Roger J. Gray  
620-28-5594  
Roger J. Gray  
Thurmont, Md.  
No. 1

James K. Gray  
United Brethren Co., Thurmont, Maryland  
Symond E. Greener  
Thurmont, Md.

## 5638 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont rural</b>		c. LENGTH OF STAY IN lb <b>50 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>her home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Cora May Willard</b>		4. DATE OF DEATH <b>May 15, 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 16, 1887</b>
9. AGE (In years birth day) <b>72</b>		10. IF UNDER 1 YEAR <b>19</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13. BIRTHPLACE (State or foreign country) <b>Maryland</b>		14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. FATHER'S NAME <b>James O. Harne</b>		16. MOTHER'S MAIDEN NAME <b>Annie M. Burrier</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		18. SOCIAL SECURITY NO. <b>Mr. George Willard</b>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic pneumonia</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiac disease</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b> <b>10 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 2, 1959</b> , to <b>May 15, 1959</b> , that I last saw the deceased alive on <b>May 14, 1959</b> , and that death occurred at <b>2:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>M. Franklin Birely</b>		DATE SIGNED <b>May 15, 1959</b>	
PHYSICIAN'S NAME (Type) <b>M. Franklin Birely</b>		ADDRESS (Street, city or town, state) <b>Thurmont, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-18-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Garfield, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Creager</b>		ADDRESS <b>Thurmont, Md.</b>	
24a. REC'D BY REGISTRAR <b>MAY 19 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hays</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00639

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Frederick

Maryland

Frederick

Funeral

Thurmond

20 yrs.

Funeral

Thurmond

New Home

CL-X

May 12, 1929

Willard

May

Cora

72

Jan. 16, 1857

X

White

Female

U.S.A.

Maryland

Own Home

Constitution

Annie K. Hunter

James O. Harris

Thurmond, Mo.

Mr. George Willard

M. Franklin Hively

Cecil, Maryland

St. George Cemetery

5-1-29

Funeral

Thurmond, Mo.

James O. Harris

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

5610

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05630

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital (DOA)</b>				d. STREET ADDRESS <b>244 East Seventh Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>ATLEE</b> Last <b>WOLFE</b>				4. DATE OF DEATH Month <b>May</b> Day <b>29</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Separated <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>16 Aug 1935</b>		9. AGE (In years last birthday) <b>23</b> yrs.	IF UNDER 1 YEAR Months <b>23</b> Days <b>29</b>	IF UNDER 24 HRS. Hours <b>29</b> Min. <b>59</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cement Block Plant</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles T. Wolfe</b>				14. MOTHER'S MAIDEN NAME <b>Mary Derr</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Korean Conflict 214-32-2620</b>		17. INFORMANT <b>Mrs. Mary H. Morgan (Same as item #2)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rupture Thoracic Aorta</b> 823X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Ruptured Liver + Spleen</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Auto struck abutment of culvert</b>					
20c. TIME OF INJURY Month, Day, Year <b>7 30 a.m. 5/29 19 59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) <b>Opensum Pike</b>		20f. (City or town) (County) (State) <b>Frederick Frederick Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>B. O. Thomas</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>B. O. Thomas, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-3-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 3 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	

NAME OF DECEASED [Faint text, possibly "John Doe"]		PLACE OF DEATH [Faint text, possibly "Home"]	
SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
OCCUPATION [Faint text, possibly "Teacher"]		DATE OF DEATH [Faint text, possibly "10/15/1918"]	
CAUSE OF DEATH [Faint text, possibly "Pneumonia"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
SIGNATURE OF EXAMINER [Faint signature]		DATE [Faint text, possibly "10/15/1918"]	
COUNTY [Faint text, possibly "Baltimore"]		CITY [Faint text, possibly "Baltimore"]	

10-15-18  
 BALTIMORE, MD  
 10-15-18



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05631

## 5611 - CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>Over 50 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>824 North Market Street</b>				d. STREET ADDRESS <b>824 North Market Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Effie Estelle Yingling</b>				4. DATE OF DEATH Month Day Year <b>May 25 1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-17-1873</b>	
9. AGE (In years last birthday) <b>85 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Jerome Breighner</b>		14. MOTHER'S MAIDEN NAME <b>Laura Alice *2* Waltz</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>214-36-2152</b>		17. INFORMANT Address <b>Ralph Yingling- Rt. 5- Frederick- Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>18 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>May 1, 1950</b> , to <b>May 25, 1959</b> , that I last saw the deceased alive on <b>May 25, 1959</b> , and that death occurred at <b>8 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Bernard O. Thomas, Jr.</b> M.D.				ADDRESS (Street, city or town, state) <b>Professional Bldg. Frederick- Maryland</b>			
DATE SIGNED <b>5-26-59</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Entombment</b>		22b. DATE THEREOF <b>May 27-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Frederick Mem. Park</b>		22d. LOCATION (City, town, or county) (State) <b>W. of Frederick- Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert C. Cradock</b> ADDRESS <b>Frederick, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 1 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knead</b>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the State Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

5612

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05632

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>Years</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOSEPHINE</b> Middle <b>ELLSWORTH</b> Last <b>YOUNG</b>				4. DATE OF DEATH Month <b>May</b> Day <b>25</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 27, 1915</b>	
9. AGE (In years last birthday) <b>43</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operator</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Beauty Salon</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Alvie E. Myers</b>				14. MOTHER'S MAIDEN NAME <b>Nannie Virginia Wyndham</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>218-40-2756</b>		17. INFORMANT <b>Mr. Edward L. Young-Same as Item #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>900.0 FRACTURED SKULL</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>SUB-DURAL Hematoma</b> DUE TO (c) <b>Brain Laceration</b>				INTERVAL BETWEEN ONSET AND DEATH <b>ONE DAY</b> <b>11 11</b> <b>11 11</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>100.0</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fall Down Steps and Accidents</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>1:00</b> a. m. <b>5/25/1959</b> 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Cabin</b>	
20f. (City or town) <b>Near -Brunswick, Frederick, Md.</b>				(County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>B. O. Thomas</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>B. O. Thomas, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>May 29, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Edge Hill Cemetery</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Fredrick, Maryland</b>				ADDRESS <b>Edge Hill Cemetery</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 28 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>				24c. LOCATION (City, town, or county) (State) <b>Charlestown, West Virginia</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05633

## 5639 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lantz</b>		c. LENGTH OF STAY IN 1b <b>10 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mayne</b> Middle <b>A.</b> Last <b>Zeller</b>		4. DATE OF DEATH Month <b>May</b> Day <b>12</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 9, 1883</b>
9. AGE (In years less birth day) yrs. <b>75</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Chicago</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Ritzmann</b>		14. MOTHER'S MAIDEN NAME <b>H. Johanna Mannmann</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-01-0218</b>	
17. INFORMANT <b>Fred W. Zeller</b>		Address <b>Lantz, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovascular Renal Disease</b> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Uremia</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>7-10 yrs</b> <b>3-4 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Mar. 21, 1956</b> to <b>13 May 1959</b> , that I last saw the deceased alive on <b>11 May 59</b> , and that death occurred at <b>9:50 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Blue Ridge Summit Pa 5-13-59</b>			
ACTUAL SIGNATURE <b>Harry H. Youngs, Jr.</b>		M.D. <b>Blue Ridge Summit Pa</b>	
PHYSICIAN'S NAME (Type) <b>Harry H. Youngs, Jr.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-15-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Thurmont, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Greager</b>		ADDRESS <b>Thurmont, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAY 18 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



10

Frederick

Maryland

Frederick

10 yrs.

10 yrs.

10 yrs.

May 12

May 12

May 12

Female

White

Sept. 9, 1883

Housewife

Own Home

Chicago

U.S.A.

William Hermann

Johanna Hermann

Hermann

No

212-01-0718 First W. Keller

Paris, Md.

Harry E. Youngs, Jr.

2-12-39

Blue Ridge Cemetery

Thermon, Maryland

Thermon E. Youngs

Thermon, Md.



